# APPENDIX A-2:

## Data Abstraction Tool: Perioperative Antibiotic for Cesarean Section (MAT-2a,2b)

**INSTRUCTIONS**: Hospitals must refer to the appropriate version of data dictionary for abstraction guidelines that apply to this measure. Use of ***italic and underlined font*** throughout this tool indicates updated text has been inserted. The capital letters in parenthesis represents the field name that corresponds to the data element name.

1. Provider Name (PROVNAME) _____

2. Provider ID (PROVIDER-ID)_____ (AlphaNumeric)

3. First Name (FIRST-NAME) _____

4. Last Name (LAST-NAME) _____

5. Birthdat**e** (BIRTHDATE) ___ ___ -___ ___ - ___ ___ ___ ___

6. Sex (SEX) □ Female □ Male □ Unknown

7. Postal Code What is the postal code of the patient's residence? (POSTAL-CODE) __ __ __ __ __ __ __ __ __
   Five or nine digits, HOMELESS, or Non-US

8. Race Code – (MHRACE) Select One Option
   - □ R1 American Indian or Alaska Native
   - □ R2 Asian
   - □ R3 Black/African American
   - □ R4 Native Hawaiian or other Pacific Islander
   - □ R5 White
   - □ R9 Other Race
   - □ UNKNOW Unknown/not specified

9. Ethnicity Code – (ETHNICODE) __ __ __ __ __ __
   (Alpha 6 characters, numeric is 5 numbers with – after 4th number)

10. Hispanic Indicator- (ETHNIC)
    - □ Yes
    - □ No

11. Hospital Bill Number (HOSPBILL#) __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
    (Alpha/Numeric – field size up to 20)

12. Patient ID i.e. Medical Record Number (PATIENT-ID) __ __ __ __ __ __ __ __ __ __ __ __ (Alpha/Numeric)

13. Admission Date (ADMIT-DATE) ___ ___-___ ___-___ ___ ___ ___

14. Discharge Date (DISCHARGE-DATE) ___ ___-___ ___-___ ___ ___ ___

15. Was the patient involved in a clinical trial during this hospital stay relevant to the measure set for this admission? (CLNCLTRIAL)
    - □ Yes (Review Ends)
    - □ No

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16. What was the patient's discharge disposition on the day of discharge? (DISCHARGDISP) (Select One Option)

- □ 01 = Home
- □ 02 = Hospice- Home
- □ 03 = Hospice- Health Care Facility
- □ 04 = Acute Care Facility
- □ 05 = Other Health Care Facility
- □ 06 = Expired
- □ 07 = Left Against Medical Advice / AMA
- □ 08 = Not Documented or Unable to Determine (UTD)

17. What is the Medicaid Payer Source? (PMTSRCE)

| Payer Source Code | DHCFP Payer Source Description |
|---|---|
| ☐ 103 | Medicaid (includes MassHealth) |
| ☐ 104 | Medicaid Managed Care – Primary Care Clinician (PCC) Plan |
| ☐ 108 | Medicaid Managed Care- Fallon Community Health Plan |
| ☐ 110 | Medicaid Managed Care – Health New England |
| ☐ 113 | Medicaid Managed Care – Neighborhood Health Plan |
| ☐ 118 | Medicaid Mental Health & Substance Abuse Plan- Mass Behavioral Health Partnership |
| ☐ 207 | Network Health- Cambridge Health Alliance MCD Program |
| ☐ 208 | HealthNet – Boston Medical Center MCD Program |
| ☐ 119 | Medicaid Managed Care Other (not listed elsewhere) |
| ☐ 98 | Healthy Start |
| ☐ 178 | Children's Medical Security Plan (CMSP) |

18. What is the patient's MassHealth Member ID? (MHRIDNO) All alpha characters must be upper case

_____

19. Does this case represent part of a sample? (SAMPLE)

- □ Yes
- □ No

20. Did the patient have a confirmed or suspected infection during this hospitalization prior to the c-section or were her membranes ruptured for ≥ 18 hours? (CONFSUSPINFECT)

- □ Yes (Review Ends)
- □ No

21. Did the patient receive an IV antibiotic for a reason other than GBS or Cesarean section prophylaxis within 24 hours prior to surgical incision time? (PROPHYLAXCSECT)

- □ Yes (Review Ends)
- □ No

22. Were there any other procedures requiring general or spinal anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay? (OTHERSURG)

- □ Yes (Review Ends)
- □ No

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23. On what date did the Cesarean Section start? (CSECTDATE) ___ ___-___ ___-___ ___ ___ ___
(MM-DD-YY or UTD)

24. At what time was the initial incision made for the Cesarean Section? (INITINCISIONTIME)

___ ___:___ ___ (military format – HH:MM or UTD)

25. Was an IV antibiotic administered to the mother in the perioperative period for Cesarean section surgical prophylaxis? (ABXCSECTION)

□ Yes

□ No (Review Ends)

26. Which IV antibiotic was administered? ( NAMEABX) (Select One Option)

□ 1 - Ampicillin (go to question #28)

□ 2 - Cefazolin (go to question #28)

□ 3 - Gentamycin (go to question #28)

□ 4 - Other

27. Did the patient have any allergies, sensitivities, or intolerances to any of the recommended antibiotic classes for this measure? (ANTIALLERGY)

□ Yes

□ No

28. On what date was the antibiotic administered? (DTABX)

___ ___-___ ___-___ ___ ___ ___ (MM-DD-YY or UTD)

29. At what time was the antibiotic administered? (TMABX)

__ __:__ __ (military format – HH:MM or UTD)